

## **Wilderness First Aid Course** ***INFORMATION***

Thank you for your interest in the Wilderness First Aid course offered by St. Vincent Indianapolis Hospital in partnership with the Indiana Department of Natural Resources and Indiana Conservation Officers.

The course on October 4 & 5, 2008 will be held at O'Bannon Woods State Park in Corydon, Indiana. This is the Wilderness First Aid 16 hour Standard course and does not include instruction in CPR. Additionally, the textbook (included in the course tuition fee) is the same book utilized for the Wilderness First Aid 32 hour Advanced course, therefore please be advised that we will not cover all of the material contained in the textbook during this course.

### **Payment Information**

To enroll in the course please complete the application and student information sheet, which follows, and mail it along with a check or money order for \$130.00 (made payable to ST. VINCENT HOSPITAL) to:

WFA Course  
St. Vincent Hospital - EMS Education  
2001 W. 86<sup>th</sup> Street  
Indianapolis, IN 46260

You may also pay by credit card and mail or fax your application & student information sheet along with the credit card payment form to the above address or fax number (317) 338-2017, ATTN: Cheryl Garvey.

A participant packet with location, course details, and camping/hotel information will be emailed to each person once payment is received. **Enrollment for this course is limited, is on a first come, first served basis, and payment is required at time of application to guarantee your place in the course.**

If you have any questions about the course, please contact:

Jim Floyd, M.Ed., WEMT, PI, CTC – Lead Wilderness Instructor  
Cell: (317) 281-7591  
Email: JMFloyd@stvincent.org

**Wilderness First Aid Course**  
***Application & Student Information Sheet***

Name: \_\_\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

County Of Residence: \_\_\_\_\_

Telephone Numbers Home: \_\_\_\_\_ Work: \_\_\_\_\_

Pager: \_\_\_\_\_ Drivers License # for Training Records \_\_\_\_\_

Email Address: \_\_\_\_\_

Date and Location of Wilderness First Aid Course You Wish to Attend:

\_\_\_\_\_

What is the highest grade/level of education you have completed?

\_\_\_\_\_

Why do you want to learn Wilderness First Aid? What do you plan on doing with the knowledge?

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What outdoor experience do you have (none required)?

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Do you have any allergies, for example, bee stings, to latex, etc.?

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Do you have any learning disabilities you would like to disclose? If so, please explain:

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Emergency Contact Information

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone Number(s) \_\_\_\_\_

I hereby request admission to the Wilderness First Aid course offered by St. Vincent Hospitals and Health Services. I understand that St. Vincent Hospitals and Health Services does not provide job placement services, nor guarantees that I will gain employment as a result of completing this course. I further understand that must complete all aspects of the course, including testing, to be eligible for third-party certification.

Additionally, I understand that it is **MY OWN RESPONSIBILITY** to cover my own injuries or illness which may occur during training. I understand that the program will not cover any injuries or accidents that might occur during classroom participation, field participation, outdoor hikes, scenarios, and/or exercises. I agree and understand to participate in the course **AT MY OWN RISK**.

By my signature below I agree to be bound by the terms of this application and attest that I am in good physical condition and am participating in the course of my own free will and volition.

Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_

Parent or Guardian Signature of consent and release if student is under 18 years of age:

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Date \_\_\_\_\_

# Credit Card Payment Form

Circle: VISA    MASTERCARD    DISCOVER    AMERICAN EXPRESS

Card # \_\_\_\_\_

Security 3 digit code on back: \_\_\_\_\_ (4 digits on front of AmEx)

Expiration Date: \_\_\_\_\_

Amount Authorized to Charge: \$ \_\_\_\_\_

Name as Appears on Card: \_\_\_\_\_

Card Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

I authorize St. Vincent Hospital to charge my credit card for the amount indicated.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date